AMERICAN MEDICINE: TECHNOLOGY OUTRUNS SOCIAL USEFULNESS*

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AMERICAN medicine is at a pinnacle of technical advance and success that could not have been dreamed of a generation ago. From the ultramicroscopic nature of life itself to complex transplant surgery, from computer diagnosis to antibiotics, the scientific achievement is incalculably brilliant. Public health activity has eliminated the bulk of epidemic disease. Three million people work in association with health services in the United States in more than 7,000 hospitals and 20,000 other health institutions. And we are not stingy in supporting this medical establishment. This year close to $60 billion, about 6.5% of the Gross National Product, will pay for our health services.

At the same time there is a desperate crisis in health services. Millions of people are without health services or poorly served. A majority of the population expresses dissatisfaction with the arrangements and their cost—they find difficulty in getting the health service they want, when they want it, and in a personally satisfying way. Minor political skirmishes such as the imbroglio over the recent proposed appointment of Dr. John Knowles to the post of assistant secretary of health become bitter controversies over the organization and cost of medical services and the proper role of the medical profession.

A great deal is made of the deficiencies of health services to the poor, and this is surely the case. The poor do suffer disproportionately and unduly from the inequities of the system. But let us not delude ourselves. We are all victims of the disorganization and maldistribution of health-care services. The poor suffer the deficiencies in more exaggerated form.

The inability to find a doctor on Wednesday afternoon or Sundays,

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frustration in the emergency room, overcrowded clinics, the desperate search for the right doctor for the right condition, the hazardous hospital situation, all of these are ominously developing into worse and worse conditions for the poor, for the middle class, and for the well-to-do as well. There needs to be change, and not just for the poor. In many ways, when we talk of "ghetto health needs" we are like the physicians who used to talk about tropical medicine as if it were a unique type of medicine. Now we know disease in the tropics is compounded by poverty and lack of medical resources.

We have gone beyond the "Negro problem" to recognize the complex of social failure that it epitomizes. We need to go beyond the "ghetto health problem" to see the professional and social problems there. Poor people of whatever color are sicker and need more care; as a matter of fact, some of their poverty may be due to their illness. But there is less health care available to them.

It is fashionable today to talk of crisis: in the cities, in the ghetto, in the schools, in the dollar. There is hardly a place, institution, or idea that is not in crisis. It seems to escape us that crises are not accidents that come upon us without notice, without our fault or contributory guilt. Crises have histories too.

We have already been deep in the crisis in health care much longer than in some of the other crises we talk about. The report of the President's Commission on Health Manpower a few years ago stated flatly that medicine was in crisis. To go back even further, the Committee on the Costs of Medical Care, which was set up in 1928, and reported in 1932, made a similar announcement. The conditions describing the grave nature of the deficiencies in health services and the opportunities for resolving them were clearly spelled out in that report about 37 years ago.

The crisis in health care arises from the nature of our health-care system. The structure is out of date, and the more we tinker with it the more we expose its failure to respond to expressed need.

Why is it more urgent now to do something about it? As one folk singer says, the times they are changing and new winds are blowing. There is an increasing awareness that the demands upon us in every aspect of our social life require that we be more attentive to gross defects in the social fabric. Recognizing this, we must do what can be

done to make effective change. John Gardner has said, "History is not going to deal kindly with a rich nation that will not tax itself to cure its misery."

De Tocqueville wrote, "The evils which are endured with patience as long as they are incurable, seem intolerable as soon as hope can be entertained of escaping from them."

The unfortunate fact is that those who see about them the possibilities of change do not want to accept the bitter realities.

In the days of the five-cent beer with free lunch, not too much was expected of medicine or of doctors. In those days doctors were well distributed throughout the country, even in the most isolated places. As a matter of fact there was a better distribution of physicians in rural than in urban America. Hospitals were scarce, but then, most medical practice was outside hospitals—even surgery, and certainly childbirth. We did not have to worry about long-term care, nursing homes, middle medical institutions, convalescent homes, and the like, because the extended family took care of its own. There were always spinster aunts, young cousins, and all sorts of other people to look after the aged, the feeble, the handicapped, the mentally deficient, and those recovering from or failing to recover from chronic illnesses. As a matter of fact, there was very little in the way of chronic illness because people did not live long enough to fall prey to it. Birth rates and infant death rates were high. Life expectancy was no more than 40 or 50 years; degenerative diseases did not begin to have their marked effects on demand for medical services and social institutions until later.

But the character of the physician-advisor, guide to the family, possessor of a few remedies that sometimes worked and many more that did not, his location and easy availability, set in people's minds a certain pattern of what medicine is or ought to be, and they would like to have it again.

In the interval technological advance has changed the capability of the physician enough to make a difference in the outcome, although actually most of the credit should be given to the public-health activities of nonphysicians (usually over the strenuous objections of organized medical bodies): to chlorinate water, eliminate infectious disease and, by preventative measures socially applied, to reduce the major causes of death that carried away our grandfathers and grandmothers in early life.

And the technological changes have had other effects. They brought with the blessings of science the concentration on and worship of the scientific method. As a consequence medicine has been diverted from dealing with people to dealing with "problems." This meant being concerned more about the fascinating variety of illness than about the people who were beset by these illnesses. The students of medicine flocked into scientific training. They stayed on to continue their scientific endeavors and concentrated around the institutions committed to science. They failed to distribute themselves appropriately and clustered around universities rather than in areas where people live. The emphasis on quality and specialism, with the attendant cost of long-drawn-out training appreciably reduced their numbers and broke up the multivalent physician into a multitude of physicians, which made it necessary to see five or six or 20 doctors for appropriate diagnosis and treatment. This multiplied the number of doctors that would be needed at a time when their number was failing to increase.

Parallel with this, of course, was the machinery that accompanied technological advance, which necessitated the employment of hundreds of thousands, and even millions, of technically expert people to deal with the new mechanical, electrical, and other devices that went into the making of modern medicine and multiplied its cost.

And the advances created new problems as they solved old ones. The changing population which resulted added demands on the medical-care system: an aging population; the decline in infant mortality, which gave us more children who needed to be cared for; the associated increase in chronic and degenerative diseases that made increasing demands on the complicated equipment, technical expertise, and specialized qualifications of the diminishing pool of physicians.

Of course we must not forget that, as more could be done, advances in communications spread the word, informing larger and larger numbers of people, giving them hope, and sending them clamoring for the helpful curative services.

There was more recognized need, more demand, and fewer available doctors; there was more technical capability, more patients, more institutions to give care, and more cost.

Frustration began here. No one likes paying more and more for less and less.

Since these facts are all so plain, why have not the intelligent, well-

educated, rational human beings who compose the professional personnel and the patients—all of us, in other words—moved in step to make all these things available? When Henry Ford produced his car it did not take too long to get cars to everyone who wanted them and could afford them; now we have more cars than we know what to do with as we pave this country with concrete.

We are not lacking in solutions. There is hardly a person who, having suffered in consequence of the deficiencies in medical-care services, has not come up with a solution. There is the manpower solution: more hands will solve the problem. Organization will solve the medical-care problem. Group practice is the solution. Others prescribe national health insurance, twice as many medical schools, a nationalized health service.

And the result of 30 or 40 years of talk and argument and recommendations is—nothing.

An able British student of these affairs, Professor Thomas McKeown of Birmingham, wrote (20 years ago!): "Both political parties practice a form of political contraception, in which no matter how suggestive the preliminary movements, there are no embarrassing legislative consequences."

It is of no real value to assess blame, because there is more than enough blame to go around. We may recall, in this connection, Pogo's telling us "We have met the enemy and they is us."

Among the responsible elements we must rate ignorance very high. Many people know the problems, but few can cope with the answers because there are so many different threads that must be woven together. Most people prefer simple solutions.

Then there is apathy—"those who ain't hurtin' ain't fightin.'" Too many people are getting just enough out of the system to make them believe it is unnecessary to make major changes.

And there is fear of the unknown by patients who believe that they may be disestablished if they antagonize the professional and lose access to medical care altogether. There is fear on the part of the professional of losing his privileged position. In a sense this stems from the guild character of professional groups, who tend to do whatever is necessary to retain their status, to maintain a scarce labor pool, and to keep salaries high.

There is the vested interest of rich doctors, administrators, and hos-

pital boards who want no change that would put them in secondary roles or make them less likely to earn as much as they do now.

Private insurance, whether nonprofit like Blue Cross, or commercial, has failed us. Knuckling under to the professional interests, such insurance has failed to protect the consumer against exploitation and quality defects and has sold him into bondage for financial considerations.

Some great organized consumer bodies, such as trade unions, have been remiss too. They have not used their united strength to bargain collectively for the 60 million people they represent to obtain more national and satisfactory organized health services.

There is racism; and discussion of this topic cannot be omitted in today's world without a clear recognition that something desperately needed by blacks, Mexican-Americans, and Indians is not necessarily what the rest of us think we ought to pay for out of our taxes.

There is a standard disposition in our public-private partnership to be stingy with the poor and generous with the rich. This is evidenced by the road-building mania and payments to rich farmers while public transportation and food programs for the poor go begging.

There is the obsession left by generations of intimidation about communism and "socialized medicine," so that anything that smacks of effective government action will be immediately labeled as such.

And, of course, there is bureaucracy, that great dragon that lies across all federal, state, and local programs. Of the many sins of which we are guilty no doubt the greatest is bureaucracy.

Still, it is hard to separate out the victims and the villains. Like wars in which there are no victors, only survivors, this battle is also one in which all are vanquished. The federal establishment may bear a heavier share of the blame because of its larger share of responsibilities.

The tangle of federal programs spawned sporadically and capriciously with no design or goal or over-all policy is inexcusable. A dozen agencies have health-care responsibilities: Health Services and Mental Health Administration for comprehensive planning and services; the Children's Bureau for child and maternal health services; the Office of Economic Opportunity, for comprehensive care to the poor; Model Cities programs; the Department of Labor, for training subprofessionals; the Veterans Administration; the Department of Defense. And as if this were not enough, think of all the congressional committees which

have to hear testimony and prepare legislation in these various areas, and of the additional committees that have to do likewise for appropriations for programs enacted into law.

And, of course, the programs are run by officials.

Bureaucrats are a special breed. They need not say "no" and risk being fired for insubordination. They can merely do "no" by failing to carry out what was intended because they know better than the people, the Congress, and the policy makers what ought to be done.

State bureaucrats are no better. There is a comprehensive health-planning law, yet from most states there have been no plans. Model Cities programs preoccupy the states and local committees with structural problems, not programs.

Regional Medical Programs offer universities, teaching hospitals, and medical schools a golden opportunity to improve their staff and facilities. The services that did not serve the people before are now more deluxe.

Medicare and Medicaid are payment mechanisms that insure doctors and hospitals against the possibility of loss from indigent patients. They serve only to guarantee providers of care (not poor consumers!) against financial loss.

In the past two years national expenditures for health went up 25%, medical care prices 17%, medical services hardly at all. "Reasonable cost" and "reasonable charges" provide a license for freedom from cost restraints.

There is a cruel insensitivity to social need in this area on the part of the professions. But there is a heavier insensitivity on the part of officials who hesitate to apply the law in a way to make it work for people. And our leaders are no help. There is no coherent long-term policy. We move from problem to problem, never solving one before we jump into another. If we continue to buy fee-for-service medicine for the old, the young, and the poor through Title 19, through Medicare, and through private insurance programs, the cost of the services will go up and up. We might say, "So what, why shouldn't we spend that much money on health?" Well, of course we can, but we will not be getting our money's worth for the money spent. Sweden spends 3½% of its Gross National Product for health services and gets in return better medical service, more satisfactory medical care, lower infant mortality, and longer life expectancy, and fewer people die in the pro-

ductive years of their lives—all for less money. It is not money that is the problem, it is the policy which is not there that is the problem.

The present efforts to sail the health ship of state without a rudder are doomed to failure. There is no national-health policy. Until we establish one and rearrange our laws, programs, and management to achieve the results desired, more and more confusion and failure await us.

It seems to me that the strategy of the proponents of improved health care in this country in the past has been off-center. This strategy has been largely devoted to national educational programs and efforts to influence national legislation. So long as the vast majority of lay persons and of professionals have the reservations and fears that have been expressed earlier, just so long will national approaches fail. Until there are grass-roots knowledge and pressures it would seem almost hopeless to look for national solutions. The remedy will have to come from large numbers of local efforts for change. The sum of these local efforts will, in my opinion, create the formidable pressures needed for a national effort.

Yes, these national goals must be achieved. But until everyone is aware of the kinds of defects and the kinds of possibilities there will be rhetoric but no action. Right now, in every community in the country, money is being wasted, misused, or unused, because of inappropriate programs and misdirected activities. By working at the local level to improve health services, important lessons can be learned and taught as to how the whole system of health-care services can be improved.

At the very least, more than is now being done can be accomplished by introducing efficiency and economy into the local health-care system. Consumer participation will give each community the opportunity to analyze the needs, propose priorities, and get action.

We have prepared a booklet, *Rx for Action,* to help communities see how they can establish local health-task forces, what such task forces might do, and how health services can be improved locally. It is more like a menu than a cookbook. It describes what can be done, rather than how to do it. But for those communities which elect to move in this direction the Urban Coalition will provide technical assistance and consultation. Among the action programs suggested—which will vary from community to community, naturally—are such things as the improvement of hospital service through overhauling the outpatient clinic, im-

provement of emergency services; manpower-training programs to add the health workers needed to eliminate sanitation and environmental hazards; cooperative actions with medical societies for supplying added medical services where needed; developing new programs in the fields of mental health and mental retardation. The basic emphasis is on better use of existing resources rather than further multiplication of programs. The emphasis is on efficiency and economy, underlining the added services that can result from better use of existing monies and better services for the same dollars. For a more complete review I recommend *Rx for Action* to you.

Here is where we come to the joining of forces with the strong drive in this country to improve the condition of the poor and of minority groups. Until now the effort has been concentrated on the creation of improved health services for the poor.

In reviewing the variety of solutions that have been proposed in the past there is good reason to question efforts that focus on improving medical care for the poor alone. In a sense this must be a dual system, a poor system, in both senses of the word. In some cases, of course, the effort has resulted in a striking improvement of health services available, and it would be unfair to describe it as "poor" medicine. On the other hand, in the long run the creation of a dual system must have the same effect as the creation of two currencies. In addition, of course, it will tend to drain off manpower and multiply the needs and expense unnecessarily. A unified single system would undoubtedly be preferable.

Medical care for the poor in sufficient quantity and satisfactory quality will be achieved only when we have a system that guarantees equal access to all—rich and poor, black, Chicano and white, urban and rural—all over this country.

To achieve this a number of things must be done. To talk about simply increasing manpower, for example, is useless if all we are going to do is create more people like the ones we have. We need not only physicians who are oriented differently toward their profession and technicians who will do more than simply produce a mechanical response: we must have new and differently trained people to meet this society's needs for health services. Manpower will not be the answer unless it is coupled with changes in organization and structure of medical practice, and also changes in the way health care is financed.

A thoughtful administrator, Irving Lewis of the Health Services

and Mental Health Administration, has written, "The great social dilemma is that liberals, conservatives, and reactionaries have all fallen victims to the myth that the only barrier standing between a person and good medical care is his inability to pay for it. The concept that the problem of distribution can be handled by mere availability of money has proved unworkable."

As far as using the money made available in any scheme, how the providers will be reimbursed also presents problems.

The prevalent mechanism for paying physicians in this country is through fee-for-service. Under these conditions, no plan of trying to distribute medical services more equitably and of providing them in poorly served areas can be successful. Fee-for-service has a built-in inflationary character, as Title 19—the Medicaid Act—has shown. In examining mechanisms of reimbursing physicians in various countries in the world, it has been found that the method of reimbursement to which physicians are most fiercely attached in any country is the direct product of the system that provides the largest income to physicians. One must take the "ethical" stance of physicians with regard to fee-for-service with a grain of salt. It happens to be the method that assures the physician the highest possible income in this country.

When we talk of "national health insurance" or "national financing" the idea of a universal compulsory federal system springs to mind immediately. This need not be the case. The United States is uniquely blessed with a pluralistic tradition. This can be taken advantage of in designing a system that covers private and public insurance efforts, federal-tax revenues, voluntary participation, and involuntary contribution. The Scandinavian countries have a mixed insurance and health-service financing mechanism. There is no reason why we cannot adopt similar measures.

Let us lay at rest the bugaboos of "compulsory health insurance" and "socialized medicine." Let us think and talk in terms of universal national financing and how to accomplish this.

A National Commission should be directed to recommend to the federal government *how to*, not whether to, introduce a national, universal arrangement for financing health care.

We need national financing of health care on an equitable basis, and reimbursement of physicians on a basis that overcomes the inflationary effect of fee-for-service payment.

The current system of organization of practice depends to a large extent upon solo practitioners, and this system cannot possibly provide the needed complicated services people must have in the places where they must have them. Certainly solo practitioners are not going to practice in rural areas and ghettos: they have been fleeing these places for years. Urban physicians have fled to the suburbs along with all the other middle-class white people who can pay for their services.

Therefore those who recommend group practice are right. Solo practice will have to be modified to become group practice. But none of these arrangements can be imposed upon physicians and patients by fiat. Patients must have an experience with something other than solo practice to convince them that group practice will be advantageous. Physicians, too, will have to have the same experience. So far in this country there are few such examples; only 10% of the population may have had such experience and have been quite satisfied with it.

In addition, of course, the introduction of new types of health practitioners to create a level of service between that of the highly qualified specialists in group practice and general practitioners will have to be developed. So far very few of these experiments have been demonstrated and, as a consequence, very few persons in the United States are prepared to give up their nostalgic longing for the family doctor who lives a few steps away, who is available 24 hours a day, and who will provide kind and compassionate, albeit rational and scientific, quick cures for their complaints and illnesses at very little cost.

A program of action to improve the system of delivering health services is also necessary. We need a Health Policy Council, a high-level group of knowledgeable people to lay out the general outlines of what we ought to do and where we ought to be going. A further significant step would be the rationalization of our disorganized approach to the funding of health services—at least a coordinated federal attack through amalgamation of the various agencies responsible plus the amalgamation of the Congressional committees responsible.

You have heard all this before. We need better organization, national financing, more and different kinds of health workers, a straightforward national health policy.

First will have to come more consumer input. Major policy decisions in health must have the participation of citizens as well as of professionals. Every committee, every board, every advisory and op-

erating group must have such participation, especially from among groups now specifically ignored or deprived. The voice of the people must be heard.

More participation by consumers is merely a restoration of American democratic principles. Harold Laski said we must keep the experts "on tap, not on top." We need to keep our technical expertise in the health field on tap rather than on top.

If these things can be done, many of the other things will be carried out more easily: universal national financing of health services organization along modern lines, more and newer kinds of health workers, team practice. But without the input of people on national policy I doubt if anything can be done.

In a real sense, of course, this merely reiterates what has been said of other segments of society and their responsibility. Are we not our brothers' keepers? Should a drug company sell a drug it knows to be useless or dangerous only because it is in line with "business ethics"? Should institutions starve and mistreat their occupants because the profit margin is narrow? Are patients or doctors the hospital's clients?

Of course this is true of all the rest of our environment—air and water pollution, decayed and execrable housing, inadequate transportation, and the use of police instead of doctors for drug addicts.

Let us not delude ourselves, either, that we can restrict our concern to personal health-care needs. The environment is causative of a good part of the disease we have to spend so much money to treat. We must clean up the environment, eliminate air and water pollution, provide decent housing and neighborhoods, and make our living space clean. We must get rid of situations that lead kindergarten children to identify a picture of a teddy bear as a rat!

At the moment the best hope seems to be through local action in providing the educational matrix, the demonstrated experience, and some of the logical and rational ways in which these things can be done. The Urban Coalition is moving in this direction through stimulating the formation of local health task forces that will examine their own local situations and, by discussing with local people how improvements can be made on a local level, show the country at large what changes can be made nationally in these same directions.

Professionals can play a critical role in this effort. Health services for all Americans depends on concerted, intelligent action by all the

people. The education of Americans in health-care needs and in solutions to health-care problems will flow from effective local organizations for the improvement of health services. If physicians will put aside narrow guild interests, address themselves in a statesmanlike way to social problems and social needs, and participate in health task force deliberations and efforts success will be assured.